Mississippi State Department of Health
Division of Health Planning and Resource Development
Post Office Box 1700
Jackson, Mississippi 39215-1700

NOTICE OF INTENT TO CHANGE OWNERSHIP

Part I: Facility Information

Facility Name:_____

Address:_____

City, County, State, and ZIP code:_____

Telephone:_____

Number/Type Licensed Beds:_____

Type Organization (county owned, non-profit, for profit, etc.)_____

Part II: Purchaser/Lessee Information

Name of Organization:_____

Address:_____

City, State, County, Zip:_____

Telephone:_____

Changes in Number/Type of Licensed Beds:_____

Type Organization (non-profit, for profit, etc.):_____

Owner(s)_____

Part III: Seller/Lessor Information

Name of Organization:_____

Address:_____

City, State, County, Zip:_____

Telephone:_____

Owner(s):_____

Operator(s):_____

Part IV: Type/Value of Consideration

Type Transaction: _____Purchase _____Lease
_____Other (describe)_____
_____
_____

Purchase/Lease cost: $ _____

Fair Market Value $ _____

Part V: Expected date of transaction: _____

Part VI: Please provide the following:

(a) The proposed (agreed upon) sales contract/lease agreement executed by the principals.

(b) **NURSING HOMES ONLY.** Certification, from the Division of Medicaid, that no increase in allowable costs to Medicaid will result from revaluation of the assets or from increased interest and depreciation as a result of the proposed change of ownership.

Part VII: Complete and sign the attached Certification page.

Submitted by: _____
NAME (type)

_____
TITLE

_____
DATE

_____
ADDRESS/(if different from page 1)

CERTIFICATION

I (we) do solemnly swear or affirm on behalf of _____, after diligent research, inquiry and study, that the information and material, contained in this foregoing Notice of Intent to Change Ownership is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi state Department of Health and the Division of Medicaid, Office of the Governor, will rely on this information and material in making their decision as to the exemption from Certificate of Need Review, and if it is found that the application contains distorted facts or misrepresentation or does not reveal truth and accuracy, the Department may require Certificate of Need review.

I (we) solemnly swear or affirm that no revision or alteration of the Notice submitted will be made without notifying the Mississippi State Department of Health.

____Yes ____No Both Seller and Buyer has agreed to Terms of purchase/lease agreement.

Seller(s) /Lessor(s) Signature(s)

Owner(s)_____ _____

Operator(s):_____ _____

Title/Date:_____ _____

Purchaser(s) Signature: _____

Title/Date: _____ _____

STATE OF MISSISSIPPI
COUNTY OF _____

Sworn to and subscribed before me, this the _____ day of _____, 20 ___

_____
Notary Public

_____
My Commission Expires

Revised 1/28/05